Joint Welfare Fund LU #164 Medical/Vision Claim Form

Fabian & Byrn, LLC T/P/A
Joint Welfare Fund LU #164 I.B.E.W
425 Eagle Rock Avenue, Suite 105
Roseland, NJ 07068
P: 877-228-4202
F: 973-228-4295

Member's Name (print in full)	Group #	Member ID#
	76132-	**ISC**
Home Address	Date of Birth	Daytime Phone #
	Marital Status (circle one) Single Married Divorced Widowed	Work Status (Circle One) Active Disabled Retired Other (specify)

PATIENT INFORMATION		SPOUSE INFORMATION	
Name	Date of Birth	Name	Date of Birth
Relationship to Member Self Spouse Child Other (specify	Sex Male Female	Employer Name and Address	Employment Status Active Retired Unemployed

Describe emergency and/or accident, including how and where it happened

Date sickness/injury began	Did injury occur at work	Was sickness caused by work?	Was injury caused by automobile or motorcycle accident?
	Y N	Y N	Y N If so, please provide police report

IF YOU OR ANY MEMBER OF YOUR FAMILY IS COVERED UNDER ANOTHER GROUP HEALTH PLAN, COMPLETE THE FOLLOWING SECTION

Covered Family Member (Circle One)	Name and address of Insurance Company
Self Patient Spouse Other (specify name and relationship)	

Policy or Plan No.	Insurance I.D #	Type of coverage individual Family

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT,WHICH IS A CRIME.

I hereby authorize any Insurance Company, organization, employer, hospital, physician, surgeon or pharmacist to release any information requested with respect to this claim and the attached bills. I certify that the information furnished by me in support of this claim is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. Further, I agree that, if any benefit payments are paid by the Welfare Fund for myself or my eligible dependents, and I or my dependents recover money from any person or organization accepting responsibility for these costs, I will repay the Welfare Plan for the amount of the benefit payments. My failure to cooperate with the Welfare Fund by not repaying the Plan will be reason for the Welfare Plan to withhold further Welfare Fund benefits until such monies are recouped.

Member's Signature Date Patient's Signature Date

*** Please attach medical claim form and proof of payment for reimbursement.**

Check one:

_____ **I authorize payment of medical benefits directly to the below named Doctor, Provider or Supplier. Authorizations will be honored only if a valid Tax Identification Number for the provider is shown on the claim form.**

_____ **Benefits should be paid directly to me.**

Member's Signature Date